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Solidarity as a National Health Care Strategy

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It has been argued that solidarity, a normative concept of increasing prominence in the bioethics literature,[1] is a value associated much more strongly with European than American social attitudes, which typically emphasise the importance of individualism and personal freedom.[2] This difference is shown clearly in the ongoing, and increasingly heated, debate in the United States surrounding the nature of justice in health care provision. In this paper, I examine recent political events surrounding the Trump administration's attempts to repeal the *Patient Protection and Affordable Care Act* (PPACA),[3] and identify the ideological commitments they express. I note that opposition to the PPACA, and support for the Trump Administration's attempts to repeal it,[4] is grounded in appeals to the importance of personal liberty, and assertions that the cooperative, solidaristic, elements of the PPACA (and by

[1] Prainsack, B. & Buyx, A. (2017) *Solidarity in Biomedicine and Beyond*. Cambridge: Cambridge University Press; AUTHOR 2016a.

[2] Häyry, M. (2005). "Precaution and Solidarity," *Cambridge Quarterly of Healthcare Ethics* 14(02). P. 199; Prainsack and Buyx, op. cit. note 1. P. 8.

[3] Patient Protection and Affordable Care Act, (2010) "Compilation of Patient Protection and Affordable Care Act: Including Patient Protection and Affordable Care Act Health-Related Portions of the Health Care and Education Reconciliation Act of 2010," Pub. L. No. 111–148 974.

[4] Representative Diane Black, "American Health Care Act of 2017," Pub. L. No. H.R. 1628 (2017), https://www.congress.gov/bill/115th-congress/house-bill/1628.

extension, solidaristic health care systems in general) are inimical to the delivery of high-quality, affordable health care.

I argue that these claims are mistaken, and suggest one way of rejecting the implied criticisms of solidaristic practices in health care provision they represent. My defence of solidarity is phrased in terms of the advantages solidaristic approaches to health care provision have over individualist alternatives in promoting certain important personal liberties, and delivering high-quality, affordable health care. My goal is not to defend the PPACA itself, but rather to show that solidaristic health care systems typically generate high-quality health outcomes, and that they do so efficiently and cost-effectively. I argue that as a result, solidaristic systems promote certain kinds of important liberties that are neglected by the hyper-individualised approach favoured by critics of the PPACA. The conflict defined by libertarian opponents of solidaristic health care systems is not therefore between solidarity and liberty *per se*, but rather between solidarity and certain liberties for some people, and non-solidarity and other liberties for others. My contention therefore, is that the libertarian argument against health care solidarity must do more to justify its rejection of those goods promoted by solidaristic health care systems, which I argue even advocates of the libertarian position have good reasons to value.

To make this argument, I first set out the key impacts of the PPACA, noting the benefits that it generated for many, and commenting on its failures. Second, I outline the main criticisms of the Act, and explain the principles upon which they are based.[5] Third, I explain the concept of solidarity and its role in

[5] Engagement with these *political* arguments may perhaps strike some as excessively partisan for an academic paper. However, as I explain, the noted comments offer an explicit, and policy focused articulation of a specific libertarian philosophical perspective. Consequently, they offer the

bioethical practice and health policy, contrasting it with the strong individualism present in the American health care industry. Fourth, I compare U.S. health care practices with those of other countries, and note the relative economic and epidemiological costs associated with each approach. Finally, I explain how solidaristic approaches to health care provision, in which participants cooperate with and support one another, can efficiently, and cost-effectively deliver high quality health outcomes. I argue that they therefore preserve important individual freedoms which are neglected by non-solidaristic approaches which claim to prioritise individual freedom. It will be noted therefore, that this argument does not focus directly on questions of *justice* relating to the distribution of health care goods and services. Instead, my goal is to exploit concern for the personal interests, in avoiding disease, minimising economic costs, and safeguarding individual liberties, of those who oppose duties to subsidise the health care costs of other persons. This is not to deny the importance of the arguments derived from justice for the existence of duties to assist others, but rather to offer one *additional* argument in favour of collaborative, cooperative, and solidaristic approaches to health care provision.

Impacts of the PPACA

perfect set of examples with which to illustrate the broader philosophical debate about the justifications for adopting a given approach to health care provision. Further, the potential impacts of the application of the principles asserted by these comments, in terms of limitations to the accessibility of health care for millions of people, mean that not only are they the appropriate subject for an academic paper such as this, it is arguably *essential* that the academic community (particular in bioethics) engage with, analyse and, where appropriate, criticize comments of the kind discussed below.

Prior to the enactment of the PPACA, health care in the U.S.A. was largely funded through free markets in health insurance. Of those insured, 55.7%, received coverage through employer funded insurance schemes, with a further 11.4% of the insured population having purchased insurance privately.[6] In addition, 34.6% of insured Americans received insurance through government insurance programmes, such as Medicaid[7] or Medicare,[8] Federal insurance programmes for low-income, and elderly and disabled people respectively, or through the military.[9] In total, 86.7% of Americans had some form of health insurance.

It is worth noting that each of the individual insurance systems present in the American health care market, with the possible exception of Medicaid and Medicare, is in itself a closed solidaristic enterprise, in that the members of each scheme share costs and risks, and thus engage in tacit, if not overt, solidaristic cooperation, within the confines of the scheme itself. Medicaid and Medicare differ slightly from this trend, in that as federal programmes, a proportion of their costs are covered by those who are not enrolees, meaning that solidarity is directed towards enrolees from outside the group. In this regard, the American health care industry should be acknowledged as including some solidaristic elements. However, this solidarity is typically limited to those within closed groups created by insurance

[6] Barnett J. C. & Berchick, E. R. (2017). *Health Insurance Coverage in the United States: 2016*. Washington DC: U.S. Census Bureau. P.4.

[7] "Medicaid | Medicare.Gov," accessed April 12, 2017, https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html.

[8] "What's Medicare? | Medicare.Gov," accessed April 12, 2017, https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html.

[9] Barnett and Berchick, op. cit. note 9. P.4.

providers (though employer provided insurance programme typically receive tax subsidies which represent indirect solidarity directed towards enrolees from those outside of the group), who enjoyed authority to include, exclude, or expel (potential) group members as they saw fit.[10] This authority to exclude, combined with the freedom enjoyed by insurers to set prices were leading causes of the limited accessibility of health care for many in the United States. Despite the presence of this limited, closed-group solidarity within certain aspects of the American health industry, the system as a whole was far more individualistic than those of most other wealthy countries.

While the PPACA retained many of the market mechanisms which characterised the health industry prior to its enactment,[11] the Act introduced stringent new regulations of the insurance industry, extended protections for consumers, expanded access to health insurance, and increased the number of people eligible for Federal Medicaid assistance.[12] The aim of these changes was to improve the accessibility of insurance markets and expand enrolment in insurance programmes, simultaneously thereby driving down costs for enrolees, and making health care available to all. The Act therefore represented a paradigm shift in the way in which health care was funded and regulated in the United States, and can be seen as an attempt to extend the health care related solidarity confined within individual insurance schemes and Federal programmes to the American health care industry as a whole.

[10] AUTHOR 2013.

[11] Gaffney A. & McCormick, D. (2017). "The Affordable Care Act: Implications for Health-Care Equity," *The Lancet* 389(10077). P. 1444.

[12] Author op. cit. note 13.

However, while the Act did improve access to health care for many Americans,[13] by removing the ability of insurers to deny coverage to people with "pre-existing conditions" for example,[14] it was not without its (arguably major) flaws. For example, although the PPACA did reduce the number of Americans without insurance, it is predicted that even if the Act is not repealed by the Trump Administration, "28 million people will remain uninsured in 2024 and beyond".[15] Further, significant levels of inequity persist in access to health care – levels of uninsurance are far higher for Black and Hispanic people than they are for white people, for instance.[16] Similarly, certain structures of the PPACA which were intended to reduce costs, such as allowing insurers to establish "narrow networks" of approved health care providers, have been criticised for enabling them to exclude health centres which provide care for expensive to treat conditions.[17] In such cases, costs are kept down by reducing the frequency with which an insurance scheme will have to cover the costs of expensive treatment – a strategy which may have the effect of reducing the availability of treatment for expensive to treat conditions, especially for poor people.[18]

Narrow networks have also restricted the range of options enrolees have in their choice of doctor – a consideration which may be argued to significantly restrict an important personal freedom, particularly if one is no longer able to receive

[13] Blumenthal, D., Abrams, M. & Nuzum, R. (2015). "The Affordable Care Act at 5 Years," *New England Journal of Medicine* 372(25). P.2452; Gaffney and McCormick, op. cit. note 14. P.1443.

[14] AUTHOR op. cit. note 13.

[15] Gaffney and McCormick, op. cit. note 14. p. 1445.

[16] Ibid: 1445.

[17] Howard, D. H. (2014). "Adverse Effects of Prohibiting Narrow Provider Networks," *New England Journal of Medicine* 371(7). Pp. 591–93.

[18] Ibid: 592; Gaffney and McCormick, op. cit. note 14, pp. 1445–46.

treatment from a physician with whom one has developed a close relationship.[19] Correlatively, the requirement that all insurance packages must cover at least a minimum range of health risks limits the freedom to make decisions about personal health risks and how to manage them, by obliging people to purchase insurance which may provide more or different coverage than they would prefer. An additional consequence of this requirement is that enrolees are likely to have to purchase insurance for health services that they personally will never use, a consideration I discuss in the following section.

It is worth noting however, that a survey by the Henry J. Kaiser Family Foundation found that 66% of those who had purchased health insurance through open markets regulated by the PPACA rated that insurance as "good" or "excellent".[20] Additionally, at least some of the failures of the PPACA can be attributed to significant ideological opposition and political obstruction. For example, the PPACA originally required all states to expand their Medicaid programmes and guaranteed federal funds to cover the cost of this expansion, in order to improve the accessibility of health care for low income people. However, following the Supreme Court of the United States of America's decision in *National Federation of Independent Business v. Sebelius*,[21] this requirement became optional. By the end of

[19] "Fact Check: You Can Keep Your Own Doctor," accessed October 11, 2017, http://politicalticker.blogs.cnn.com/2013/09/26/fact-check-you-can-keep-your-own-doctor/. Retrieved 27 October 2017.

[20] Hamel, L. et al., (2016). "Survey of Non-Group Health Insurance Enrollees, Wave 3". Washington DC: The Henry J. Kaiser Family Foundation. https://www.kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/. Retrieved 27 October 2017.

[21] Supreme Court of the United States, (2012). NATIONAL FEDERATION OF INDEPENDENT BUSINESS ET AL. v. SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., No. 11–393. Supreme Court

2015, 19 States had opted out of the PPACA's federally funded Medicaid expansion, severely limiting the accessibility of health insurance for low income residents.[22] However, regardless of the reasons for these weaknesses of the PPACA, it remains true that some people are not well served by the Act, and it can be interpreted as imposing restrictions on certain kinds of arguably important freedom. In the following section I briefly outline the political rhetoric presented in opposition to the PPACA, and identify the philosophical commitments it implies.

Solidarity vs. Individualism in American Health Care

The debate surrounding justice in the provision of health and health care in the United States (and elsewhere) is long-running,[23] and characterized by heated disagreement about the extent, and even existence, of entitlements to health care, the identities of the people who enjoy such entitlements, and the duties correlating to them.[24] The status of the PPACA was

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of the United States of America; Rosenbaum, S. & Westmoreland, T. M. (2012) "The Supreme Court's Surprising Decision On The Medicaid Expansion: How Will The Federal Government And States Proceed?," *Health Affairs* 31(8). Pp.1663–72.

[22] Han, X. et al., (2016). "Health-Related Outcomes among the Poor: Medicaid Expansion vs. Non-Expansion States," *PLOS ONE* 10(12). P.e0144429.

[23] Plaut, T. F. A. & Arons, B. S. (1994) "President Clinton's Proposal for Health Care Reform: Key Provisions and Issues," *Psychiatric Services* 45(9), 871–871; Gottschalk, M. (1999). "The Missing Millions: Organized Labor, Business, and the Defeat of Clinton's Health Security Act," *Journal of Health Politics, Policy and Law* 24(3). Pp. 489–529; Budetti, P.P. (2004) "10 Years beyond the Health Security Act Failure: Subsequent Developments and Persistent Problems," *JAMA* 292(16). Pp.2000–2006.

[24] Fried, C. (1975). "Rights and Health Care — Beyond Equity and Efficiency," *New England Journal of Medicine* 293(5), pp.241–45; Daniels, N. (2008) *Just Health: Meeting Health Needs Fairly*. Cambridge,

arguably one of the most important campaign issues in both the 2012 and 2016 presidential elections, and has only grown more contentious during the presidency of Donald Trump.[25]

Political discourse surrounding opposition to the PPACA is centred on two closely related claims; first, that the Act is inherently incapable of enabling the delivery of high-quality health care.[26] Second, that the legal requirements of the Act impose unjustifiable restrictions on important personal liberties.[27] First, it has been argued that by denying insurers the right to refuse insurance coverage to people with expensive health needs the PPACA would lead to a collapse of the health insurance market, leading to significant restrictions on the availability and accessibility of care. By requiring insurers to sell insurance to people with pre-existing health conditions and expensive health needs, it was argued that the membership of insured groups would become dominated by a higher proportion of people with immediate and/or more-costly health care needs. Since these people are more likely to make claims on their insurance this was argued to lead to higher costs for insurance providers.[28]

UK: Cambridge University Press; Wolff, J. (2012). *The Human Right to Health*. New York, USA: W.W. Norton & Company, Inc.

[25] Ballotpedia: The Encyclopedia of American Politics, "Donald Trump Presidential Campaign, 2016/Healthcare - Ballotpedia," Retrieved 24 May 2017, https://ballotpedia.org/Donald_Trump_presidential_campaign,_2016/Healthcare.

[26] Kantarjian, H. M. (2017). "The Affordable Care Act, or Obamacare, 3 Years Later: A Reality Check," *Cancer* 123(1). p. 27, https://doi.org/10.1002/cncr.30384.

[27] Author op. cit. note 13.: Author op. cit. note 1.

[28] C-SPAN.Org (2017). *Speaker Ryan Explains GOP Health Care Plan Amid Growing Opposition*. https://www.c-span.org/video/?425131-1/speaker-

Consequently, because there would then be proportionately fewer people in the risk pool who do not make insurance claims, the income from premiums paid by healthy enrollees will gradually fall below the level at which it is sufficient to cover the cost of care for less healthy enrollees.[29] In response, insurance providers would be incentivized to increase the cost of premiums in an attempt to cover the health care costs of their enrollees and maintain profits. Doing so however, is also likely to encourage more people to opt-out of buying insurance, further undermining the sustainability of the insurance market.[30] According to Paul Ryan, Speaker of the United States House of Representatives, the PPACA entered this "death spiral" and failed to adequately control the costs of health insurance precisely because it relied upon young and healthy people engaging in solidarity with older, sicker people.[31]

Second, the Act has also been criticized over the extent to which it obliges citizens to purchase insurance which provides coverage for services which they may not want, and to which they may be ideologically opposed.[32] Here, opposition centered on the importance of personal freedom, and the notion that the requirements of the Act violated the rights of Americans to be

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ryan-explains-gop-health-care-plan-amid-growing-opposition. 06:42 of the video. Retrieved, 17 October 2017.

[29] Vinik, D. (2017, March 3). "Three Misleading Claims from Paul Ryan's Obamacare Lecture," *Politico: The Agenda*, http://www.politico.com/agenda/story/2017/03/three-misleading-claims-in-paul-ryans-obamacare-lecture-000349. Retrieved 10 October 2017.

[30] Ibid.

[31] C-SPAN.Org. op. cit. note 35. 13:18 of the video.

[32] Parker, M. (2017, March 11). "Shimkus: Men Paying for Prenatal Care Coverage like Buying a Cabin 'You're Never Going to Use,'" *The Southern*, http://thesouthern.com/news/national/shimkus-men-paying-for-prenatal-care-coverage-like-buying-a/article_b86775bd-6a8e-5d33-9f2e-1670ee1bb015.html. Retrieved, 25 May 2017.

free to choose what, if any, insurance they needed.[33] In support of this view, health insurance was argued to be a commodity, which should be available through an open market, allowing Americans to purchase only the specific coverage they want, and avoid services that they did not want, thereby promoting their freedom of choice.[34] Correlatively, it was also argued that requiring all insurance schemes to cover certain "essential health benefits"[35] similarly restricted the rights of insurers, and employers with responsibilities to provide insurance to employees,[36] to provide coverage only for those goods they freely chose. This last consideration was particularly important in a series of legal cases in which it was argued that the requirement to contribute to the cost of certain controversial services (such as abortion or contraception), which were held to be immoral by some people, violated important rights to freedom of conscience.[37]

Each of these criticisms of the PPACA is grounded in a commitment to the primary importance of certain kinds of negative liberty, either for instrumental reasons (i.e., that promoting liberty preserves health care markets), or because it is taken to have intrinsic lexical priority over other valuable goods. It is unclear however, how well these commitments were served by the American health care industry prior to the advent of the PPACA. As I argue below, the hyper-individualised approach to health care provision overlooks certain important kinds of liberty, and can restrict liberty and the accessibility of health care for many people. For instance, in 2013,

[33] AUTHOR, op. cit. note 13.

[34] Ibid.

[35] Patient Protection and Affordable Care Act, op. cit. note 3. sec. 1302(b)(1), http://www.hhs.gov/healthcare/rights/law/.

[36] Author 2016b.

[37] AUTHOR, op. cit. note 13.: AUTHOR, op. cit. note 45.

approximately 41.8 million Americans lacked insurance.[38] I also argue that the claim that solidaristic systems of health care provision are unsustainable, or unable to deliver quality care is of questionable force, given the success of such systems in most other wealthy countries. To make this argument, I first briefly outline the various definitions of solidarity, and explain how the core implications of the concept are present in the health care systems of most wealthy countries.

Solidarity in Health Care Provision

The concept of solidarity has a lengthy history in political and social philosophy.[39] It is present, by implication at least, in the social contract traditions of the 18th Century,[40] in which the emergence of the state was argued to be grounded in the "universal human need for society and protection from harm".[41] More recently, solidarity as emerged as a central concept in bioethical discourse, with its core features and implications being the subject of extensive debate.[42] It has been argued, for example, to play an important role in motivating the fulfillment of duties to contribute to the health care needs of other persons

[38] Barnett & Berchick, op. cit. note 9. P. 4.

[39] Scholz, S. J. (2009) *Political Solidarity*. Pennsylvania: Penn State Press; Stjernø, S. (2005). *Solidarity in Europe: The History of an Idea*. Cambridge, UK: Cambridge University Press; AUTHOR 2016C.

[40] Locke, J. (1980). *Second Treatise of Government*. Indianapolis USA: Hackett Publishing: Rousseau, J.J. (2000). *Discourse on the Origin of Inequality*. Oxford, UK. Oxford University Press; Hobbes, T. (2008). *Leviathan*. Oxford, UK: Oxford University Press.

[41] AUTHOR, op. cit. note 93.

[42] Jennings, B. (2012). "The Place of Solidarity in Public Health Ethics," *Public Health Reviews* 34(1). Pp.65; Krishnamurthy, M. (2013). "Political Solidarity, Justice and Public Health," *Public Health Ethics* 6(2). Pp.129–41; van den Hoven, M. & Verweij, M. (2013). "Professional Solidarity: The Case of Influenza Immunization," *The American Journal of Bioethics* 13(9). Pp.51–52; Prainsack & Buyx, op. cit. note 1..

nationally and globally,[43] and to contribute to the development of welfare states which serve the health and social needs of all citizens.[44]

The breadth of contexts in which solidarity is increasingly held to be relevant in bioethical debate is matched by the range of accounts of the concept's defining features, as has been discussed in more detail elsewhere.[45] However, while the different interpretations of solidarity vary in their specifics, most accounts share significant common ground. To illustrate, solidarity is widely held to be "closely linked to the social, political, moral and ethical connections that exist between people",[46] and to emphasise and motivate, cooperation between persons. Similarly, most accounts of solidarity recognize it as an active concept, rather than a mere attitude – that is, to engage in solidarity with other persons, one must act on their behalf, rather than merely empathise with them.[47] For example, Bruce Jennings and Angus Dawson have described solidarity as the act of '"*standing up for", "standing up with",* and *"standing up as*"'[48] those persons with whom it is identified – an inherently active, and relational definition of the concept.

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[43] Segall, S. (2007). "In Solidarity with the Imprudent: A Defense of Luck Egalitarianism," *Social Theory and Practice* 33(2). Pp. 177–98; Widdows, H. (2011). "Localized Past, Globalized Future: Towards an Effective Bioethical Framework Using Examples From Population Genetics and Medical Tourism" *Bioethics* 25(2). P. 85; Author, op. cit, note 1.

[44] Weale, A. (1990). "Equality, Social Solidarity, and the Welfare State," *Ethics* 100(3). p.77; Ter Meulen, R., Arts, W. & Muffels, R. (2013)*Solidarity in Health and Social Care in Europe*. 69.

[45] AUTHOR, op. cit. note 94.

[46] Ibid., 1.

[47] Ibid., 2.

[48] Jennings, B. & Angus Dawson, A. (2015) "Solidarity in the Moral Imagination of Bioethics," *Hastings Center Report* 45(5). P. 35.

Prainsack and Buyx identify three "tiers" of solidarity, through which these features of the concept can be enacted; first, solidarity can occur between individuals – "[i]f Ayse suffered from regular back pain when she was pregnant and offers her seat [on a crowded bus] to Ivo who seems to have a painful back while standing up, this represents a practice of solidarity at tier 1".[49] Here, "Ayse" recognises a similarity she shares with "Ivo" and gives up her seat for her, incurring the cost of standing on a busy bus – an informal, immediate interaction. Second, solidarity can be present in group settings, represented by "[m]anifestations of *collective* commitments to carry costs to assist others" (my italics).[50] One example of such informal, collective solidarity is the emergence of networks of people with the same disease, organised to share information, provide mutual support, or raise funds for common causes.[51] This collective solidarity is distinguished from the third tier identified by Prainsack and Buyx by its informality – solidaristic cooperation emerges here from collective identification of similarities of interest, rather than the formal, legalised solidarity of tier three.

The final tier represents the most formal "institutionalised" form of solidarity "often in the form of legally enforceable norms".[52] Prainsack and Buyx describe this kind of formalised, institutional solidarity as "solidifying", and emerging from, the willingness of individual persons to carry costs to benefit others.[53] This kind of "tier three" solidarity is instantiated by the cooperative health care systems of wealthy countries like the U.K. and Germany. Systems in these countries require residents

[49] Prainsack & Buyx, op. Cit. note 1. P. 54.

[50] Ibid: 55.

[51] Ibid., 55–56.

[52] Ibid., 56–57.

[53] Author, op. cit. note 13: Author, op cit. note 44.

to contribute to the cost of universal health care provision through the payment of tax contributions, or the purchase of health insurance in a highly regulated market. In this way, costs are shared – the healthy subsidise the care costs of the sick, men contribute to the costs of women's care (and vice versa), and the wealthy aid the poor. Though it should be acknowledged that European countries do typically place some limits on the range of persons to whom solidarity is owed. For example, undocumented migrants are not usually entitled to make use of the full range of services (if any) to which documented residents enjoy access.[54] Cooperative, solidaristic systems are intended to ensure that all persons enjoy access to at least basic health care services; the PPACA sought to incorporate this kind of tier three solidarity.

Promoting Health and Liberty Through Solidarity

As discussed above, opposition to the solidaristic commitments of the PPACA is grounded in two central claims; first, the "quality" argument claims that the subsidisation of vulnerable people by the less vulnerable is unsustainable, and would lead to worse health outcomes for all. Second, the "libertarian" argument states that the solidaristic elements of the PPACA unjustifiably restricts the liberty of Americans. In this section, I examine these claims in turn, with reference to the outcomes achieved by health care systems in wealthy countries which rely, to differing degrees, on the kinds of solidaristic cooperation rejected by critics of the PPACA.

[54] Bozorgmehr, K. & Razum, O. (2015). "Effect of Restricting Access to Health Care on Health Expenditures among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994–2013," *PLOS ONE*. 10(7). P. e0131483.

First, the "quality" argument can be challenged with reference to the efficiency of, and successes in health promotion enjoyed by, solidaristic systems in other wealthy countries, and to two significant failures associated with non-solidaristic systems. As noted above, most wealthy countries employ some form of cooperative, solidarity based model to ensure that their residents enjoy access to at least basic health care services.[55] As systems involving solidaristic cooperation, they function through the kind of subsidisation, of the sick by the healthy or the poor by the wealthy, criticised as a key reason that the PPACA would be unsustainable, and unable to deliver quality care. However, as demonstrated by repeated studies, these systems consistently deliver health care to their enrolled populations more efficiently, more accessibly, and more affordably than the American approach.[56] While factors other than solidarity may have contributed to the strengths of these systems, based on these successes we can conclude that solidarity, contrary to Ryan's comments, does not inevitably lead to unsustainability, inaccessibility, or lower quality care. Indeed, it has been shown that prior to the PPACA fully coming into effect "the United States health care system [was] the most expensive in the world, but comparative analyses consistently show the U.S. underperforms relative to other countries on most dimensions of performance".[57] There is good reason therefore to view a

[55] Osborn, R. et al., (2016). "In New Survey Of Eleven Countries, US Adults Still Struggle With Access To And Affordability Of Health Care," *Health Affairs.* 35(12).

[56] Schoen, C. et al., (2010). "How Health Insurance Design Affects Access To Care And Costs, By Income In Eleven Countries," *Health Affairs* 29(12). Pp.2323–34,; Davis, K. et al., (2014). *2014 Update: Mirror, Mirror On The Wall - How the Performance of the U.S. Health Care System Compares Internationally.* New York, USA: The Commonwealth Fund; Osborn et al., op. cit. note 109.

[57] Davis et al., op. cit. note 110. P. 3.

solidaristic health care strategy as a cheaper,[58] more efficient approach,[59] which offers better health outcomes for more people,[60] than the kind of hyper-individualised strategy suggested as an alternative to the PPACA. To illustrate, when evaluating the impacts of repealing the PPACA in favour of one of the Trump Administration's failed alternatives, the American Health Care Act (AHCA), the U.S. Congressional Budget Office predicted that by 2026 there would be an additional 23 million uninsured people compared to predicted outcomes for the PPACA as a result of the repeal.[61] Largely this increase is predicted to result from restrictions of Medicaid eligibility, though the AHCA would also allow insurers to charge people with pre-existing conditions extremely high premiums, potentially excluding many from needed insurance.[62]

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[58] Reinhardt, U. E., Hussey, P. S. & Anderson, G. F. (200$). "U.S. Health Care Spending In An International Context," *Health Affairs* 23(3). Pp.10–25.

[59] Anderson, G., Chalkidou, K. & Herring, B. (2012). "High US Health-Care Spending and the Importance of Provider Payment Rates" *Forum for Health Economics and Policy*. 15(3); Pritchard C. & Hickish, T. (2011). "Comparing Cancer Mortality and GDP Health Expenditure in England and Wales with Other Major Developed Countries from 1979 to 2006," *British Journal of Cancer*. 105(11). Pp.1788–94.

[60] Schoen et al., op. cit. note 110; Davis et al., op. cit. note 110

[61] Congressional Budget Office, (2017). *Congressional Budget Office Cost Estimate: H.R. 1628 American Health Care Act of 2017 As Passed by the House of Representatives on May 4, 2017*. Washington DC: Congressional Budget Office. P.4, https://www.cbo.gov/publication/52752. Retrieved 5 November 2017.

[62] Representative Diane Black, op. cit. note 4; Doran, W. (2017, May 4). "Does the AHCA Protect Pre-Existing Conditions?," *@politifact*. http://www.politifact.com/north-carolina/statements/2017/may/04/robert-pittenger/does-new-version-ahca-protect-coverage-pre-existin/. Retrieved, 15 September 2017.

The efficiency, accessibility, and health outcomes of solidaristic health care systems provide a significant challenge to claims that such systems are inherently unsustainable, and incapable of delivering quality care. Nonetheless, in and of themselves, these considerations may not be sufficient to convince people who are ideologically opposed to solidarity in health care, or those who may see an increase in their personal financial costs as a result of obligations to purchase insurance. However, it has been argued that improving the accessibility of health care, especially for preventative services, can have significant public health benefits, which all persons have reason to value, regardless of their ability or desire to purchase insurance under an individualistic system.[63] Given that solidaristic systems have been shown to achieve higher accessibility of health care,[64] there are arguably strong self-interested reasons for all people to participate in such systems, because doing so can offer effective protections against a wide range of serious threats to health.[65]

Indeed, U.S. health care policy does rely, implicitly at least, on solidarity for the delivery of certain public health programmes, which generate benefits for all U.S. residents. For example, approximately 57% of the cost of vaccination programmes in the United States is met by federal funding.[66] While the provision of federally funded vaccines to low income people confers direct benefits to recipients, it also benefits those who pay for vaccines privately, by increasing the proportion of vaccinated people in the U.S.A., reinforcing herd immunity and reducing the risk of

[63] Battin, M. P. et al., (2009), *The Patient as Victim and Vector: Ethics and Infectious Disease*, New York, USA: Oxford University Press, p. 12.

[64] Osborn et al., op. cit. note 109.

[65] AUTHOR 2014, pp.297-298.

[66] Hinman, A. R., Orenstein, W. A. & Rodewald, L., (2004). "Financing Immunizations in the United States," *Clinical Infectious Diseases* 38(10), pp. 1440–46.

outbreaks of vaccine preventable diseases.[67] Thus, the financial costs imposed on those who contribute to funding vaccinations for other people through taxation are offset by their reduced health vulnerabilities.

However, while there are solidaristic systems in place in the U.S.A. which offer protection against the threat posed by certain infectious diseases, these are limited, and as a result are unable to compensate for vulnerabilities allowed by the predominantly individualist system. For example, an outbreak of HIV in Indiana in 2015 was largely the result of public health policy which failed to extend protections to those unable to afford them privately.[68] This outbreak was traced to "extensive needle sharing by people who inject drugs".[69] Indiana criminalises the possession of needles without a prescription and had not explicitly permitted needle exchanges, making it harder for intravenous drug users to protect themselves from the threat of infection.[70] In addition, budget cuts for health led to the closure of the only clinic providing free, anonymous HIV testing in the county at the centre of the outbreak.[71] Here, the absence of

[67] Anderson R. M. & May, R. M. (1985). "Vaccination and Herd Immunity to Infectious Diseases," *Nature* 318(6044). Pp.323–29.

[68] McCarthy, M. (2015). "Indiana Declares Health Emergency in Response to HIV Outbreak," *BMJ : British Medical Journal* 350.

[69] Rich. J.D. & Adashi, E.Y., (2015). "Ideological Anachronism Involving Needle and Syringe Exchange Programs: Lessons from the Indiana Hiv Outbreak," *Journal of the American Medical Association* 314(1). P.23.

[70] Golding, N. J. (2017). "The Needle and the Damage Done: Indiana's Response to the 2015 HIV Epidemic and the Need to Change State and Federal Policies Regarding Needle Exchanges and Intravenous Drug Users," *Indiana Health Law Review.* 189; Hulkower, R. L. & Wolf, L. E. (2013). "Federal Funds for Syringe Exchange Programs: A Necessary Component toward Achieving an AIDS-Free Generation," *Annals of Health Law.* 308.

[71] Golding, op. Cit. Note 124. Pp.207–8.

accessible public health services[72] exposed already vulnerable people to severe risk of harm, and led to the preventable outbreak of a serious threat to public health.[73]

HIV cannot be transmitted through casual contact between infected and uninfected persons, unlike diseases such as measles or tuberculosis, meaning that the risks associated with infected populations are different for HIV than they are for other "conventionally" infectious diseases. Consequently, it may be objected that it is unfair to refer to this case in support the claim that engaging in solidarity to promote public health offers epidemiological benefits to those who can privately afford treatment and prophylaxis. However, as with conventionally transmitted infections, a higher proportion of people living with HIV (or any other sexually transmitted infection) within a given community does increase the risk of further infections, regardless of the means of transmission.[74] The Indiana crisis thus provides a startling example of the public health risks associated

[72] Strathdee, S. A. & Beyrer, C. (2015). "Threading the Needle — How to Stop the HIV Outbreak in Rural Indiana," *New England Journal of Medicine* 373(5). P.398.

[73] Golding, op. Cit. Note 124. P.209.

[74] It should be acknowledged that this "epidemiological" argument, may have only limited applicability to non-communicable threats to health, such as cancer, mental illness, or injuries caused by accidents. However, as I have argued elsewhere (AUTHOR op. cit. note 119, pp.297-298.), the range of threats to health which can only be addressed through the provision of health promoting public goods is very broad. It is therefore possible to justify solidaristic approaches to health care for at least some threats to health which do not obviously pose direct, communicable threats to health. Further, as I have also argued in a recent paper, it may be possible for self-interested responses to immediate, direct threats to health to lead to motivation to cooperate to provide care even for non-communicable disease threats (AUTHOR op. cit. note 1).

with failures to deliver accessible health care services to all people.

An additional consideration, which adds weight to the argument for solidaristic cooperation in the provision of health care services, is that the financial costs of solidaristic health care systems are typically lower than their individualist counterparts.[75] To illustrate, as a result of the individualist approach to public health provisions in Indiana, the cost to tax payers of responding to the HIV crisis is estimated at between $160 and $250 million.[76] In comparison, a publicly funded HIV prevention programme in Washington D.C. cost $650,000 in its first two years of operation, and was estimated to have prevented 120 new infections, and to have saved the city $44.3 million.[77] Investing in the health of other people, through solidaristic cooperation in meeting the costs of health care can thus reduce our vulnerability to significant risk, and minimise the cost of health care overall.

There are thus good reasons, derived from self-interest, even for those who endorse an individualist health care strategy, to at least seriously consider an alternative based on solidarity. However, it may still be objected that despite the noted advantages of solidaristic health care strategies, they still impose unjustifiable restrictions on important personal freedoms, such as the freedom to choose one's physician. While these concerns should not be ignored, there are at least three reasons why they should not be taken as grounds to reject a solidaristic health strategy; first, the freedoms with which they are concerned may be of questionable or limited value. Second,

[75] Schoen et al., op. Cit. Note 110: Davis et alop. Cit. Note 110; Osborn et al. Op. Cit. Note 109.

[76] Golding, op. Cit. Note 124. P. 214.

[77] Ibid: 213–14.

general personal freedom may be promoted more effectively by placing limited restrictions on such questionably valuable liberties. Third, doing so may be required even by a view of justice which prioritizes the protection and promotion of individual freedom.

First, and most specifically to the objections discussed above, the value of the noted freedoms (to choose one's personal health care strategy and physician), and the extent to which they should be prioritized in a non-ideal context in which it is not possible to promote all freedoms is unclear. For example, the freedom to choose which health insurance to buy, if any, is presented by opponents of solidaristic health care strategies as respecting individual agency, and deferring to expertise uniquely held by each individual about their personal health needs.[78] However, the value of being free to make such choices is questionable. As has been argued by Ronald Dworkin, the economic and epistemic conditions in which such choices could be adequately informed and freely made do not presently exist; many people lack the financial resources to purchase the insurance that they would ideally choose, and most lack the appropriate expertise and knowledge to accurately evaluate their personal risks and thus insure themselves to the level that they believe is appropriate.[79] To illustrate, even if Susan has sufficient resources to purchase what she believes to be her ideal insurance package, and believes that she has insured herself to the level appropriate to her risk preferences, she is unlikely to have the knowledge and expertise to ensure that her decision is based on accurate information.[80] Thus, while Susan may be free, in the narrow sense of being able

[78] Speaker.gov, "The American Health Care Act," Website of the Speaker of the House, Speaker.gov, January 11, 2017, http://www.speaker.gov/HealthCare. Retrieved, 17 October 2017.
[79] Dworkin, R. (1993) "Justice in the Distribution of Health Care," *McGill Law Journal* 38(4). pp. 888–89.
[80] Silvers, J. B. (2013) "The Affordable Care Act: Objectives and Likely Results in an Imperfect World," *Annals of Family Medicine* 11(5). P. 403.

to make unrestricted choices, given the limitations on liberty that can be imposed by deprivations of health, it is unclear that her freedom to make poorly-informed, resource-constrained choices is in fact a valuable freedom, the preservation of which should be prioritized over other possible freedoms.

Second and correlatively, even accepting that the freedom to make unconstrained choices is valuable, it is unclear that such a freedom actually promotes personal freedom more generally. In Susan's case, it can be argued that her general liberty would be promoted more effectively if she were to "give up" this minor freedom in favour of mandatory participation in a cooperative health care system based on solidarity. While doing so will (arguably) impose some restrictions on certain freedoms, these restrictions are offset by the benefits of having access to health care, which reduces the risk that personal liberty will be constrained by deprivations of health. Correlatively, participating in solidaristic systems which serve the health needs of all people minimises the costs of protecting one's own health, thereby increasing the resources available to pursue one's own life goals and thereby promotes, rather than restricts, personal liberty. On balance therefore, it can be argued that the obligation to cooperate in a health care strategy based on solidarity promotes, rather than constrains liberty.[81]

Finally, while solidaristic health care systems typically impose lower financial burdens on their members than individualist systems, it remains possible that some people may incur higher personal costs in a solidaristic health care system. For example, someone who declines to purchase any insurance under an individualist system will incur additional costs under a system in which they must contribute financially. However, such costs

[81] Shue, H. (1996) *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy*, Second Edition. Princeton, N.J.: Princeton University Press. P.23.

are not incompatible with a strong commitment to the importance of liberty, and may be required to promote liberty more generally. Such restrictions are arguably required by Rawlsian liberalism, because they safeguard liberty more generally[82] by ensuring that all persons are able to access at least basic health care services, which Rawls acknowledges are vital for personal freedom.[83] The small sacrifice of the freedom of total control over all of one's personal resources is necessary to ensure that all persons are able to enjoy a similar system of liberties: an outcome which is not possible when the kind of absolute freedom proposed by critics of a health care strategy based on solidarity is prioritised. There are therefore, circumstances in which restrictions on personal liberty are justifiable,[84] and it is possible for restrictions on liberty in one area to promote liberty more generally, both for society as a whole, *and* for those individuals whose initial liberties are constrained.

Indeed, such minor restrictions in liberty are arguably accepted by many who favour the prioritisation of personal freedom when these costs are imposed by duties to contribute to other social goods which promote individual welfare and liberty. For example, all tax-payers in any given state contribute to the cost of having a system of laws and the means to enforce them, even if certain individuals are able to personally afford to pay for private security services. Being required to contribute to the costs of a police force with which one may never directly interact does restrict the liberty of those with private security services, in that they do not have *total* control over all of their

[82] Rawls, J. (1999). *A Theory Of Justice: Revised Edition*, Revised Edition. Cambridge, MASS: Harvard University Press. P. 53.

[83] Rawls, J. (1999). *The Law of Peoples; with, The Idea of Public Reason Revisited*. Cambridge, MASS: Harvard University Press. P. 50.

[84] Author, op. cit. note 13; Author, op. cit. note 44.

resources, but it would be implausible to suggest that they should not have to make such contributions. However, if we accept the libertarian argument outlined above with regard to health care, we must also accept the same arguments as they apply to social goods like system of laws and the means to preserve and enforce them. This is because, in both cases small sacrifices of personal liberty are demanded in order to deliver goods which promote liberty and welfare generally, and not only for those who fulfil the duties in question. It might be objected at this claim that this is because they benefit from the systemic protections of living in a stable society governed by the law more broadly, whereas there are no analogous systemic benefits associated with ensuring the universal availability of health care. However, this is to ignore the benefits of such universally available health care noted in the first half of this section.

Conclusion

Opposition to the PPACA is grounded in an ideological commitment to hyper-individualism in health care provision, which is itself justified by the asserted belief that individualistic health care strategies best promote personal liberty and quality health care. My goals in this paper have been fourfold; first, to challenge the claim that solidaristic health care systems unjustifiably restrict liberty, and deliver lower quality health care, and outcomes, to patients than individualist or libertarian systems. Second, to highlight the limitations of libertarian health care strategies, and note that while some liberties for some people are promoted by such strategies, they impose significant restrictions on the freedoms of many others. Third, in doing so, to show that the philosophical conflict at the heart of this debate is not between solidarity and liberty *per se*, but rather between solidarity and certain liberties for some people, and non-solidarity and other liberties for others. Finally, and

based on these considerations, to demonstrate that solidaristic health care systems promote goods that libertarian critics of solidarity ostensibly value, and that there are therefore good reasons for them to adopt or at least consider solidaristic national health strategies. This paper thus challenges critics of the PPACA to offer a more nuanced argument in favour of individualism, which acknowledge the limitations of their approach, and justifies their rejection of the benefits associated with solidaristic health care systems.